Provider Agreement - Billing Provider Update Form Instructions

Indiana State Department of Health

For Groups, Facilities, and Sole Practitioners

General Instructions

Please read carefully

- This form is to be used for updating billing provider information as follows:

  Address Change (Service Location, Mailing, Payment, and Home Office)

  Re-certification

  Tax ID

  Clinical Laboratory Improvement Amendment (CLIA Certification)

  Drug Enforcement Administration (DEA) Certification

  Voluntary termination

- **Please do not use this form for g*roup* member updates, or changes of ownership.**
- If you are enrolling a new service location, adding a non-enrolled group member, or are undergoing a change in ownership, it will be necessary to complete a new **Provider Enrollment Application**.

Please complete only the sections that pertain to updated information for the Provider Number and Service Location listed. Each section includes some instructions on proper completion. Please read the instructions carefully. Many of the updates require documentation to be attached, so please be sure to include a copy of the necessary documents with the form.

Mailing Instructions:

Once you have fully completed the form and enclosed copies of all required licenses, forms, and certifications, please send the entire packet to:

ISDH - 2 North Meridian Street, Provider Relations - 7B, Indianapolis, IN 46204-3021

You will be notified in writing by ISDH regarding the status of your update once your service location update has been reviewed. Please allow I5 business days for mailing and processing time.

Questions:

Please contact ISDH Provider Relations by calling 800-475-1355, with any questions regarding these forms.

PROVIDER AGREEMENT – Billing Provider Update

State Form 51404 (7-03)
Indiana State Department of Health

For Groups, Facilities, and Sole Practitioners

Provider Information

NOTE: Updates will be made to the service location specified.

Provider Number _____ Service Location _____

Provider Name: _____

Taxpayer Identification Number: _____

Contact Name: _____ Telephone Number: _____

Complete only the sections that reflect a change to your provider information.

If Your Legal Name, Mailing Address or Tax ID have changed:

A copy of a completed federal W-9 Form must be attached to this update form. Failure to attach the W-9 form will result in ISDH returning the documents you submitted with a request for the W-9 form**.**

Address Information Update? ___**Yes**

---

1. Service Location Name and Address

Please complete the Name, County, DBA Name, Telephone Number, Street Address, City, State, and nine-digit ZIP code for the actual site where services are performed. The address must be a physical location. A post office box is not a valid service location address. The Service Location name is the Doing Business As (DBA) Name for each location.

NOTE: You must complete an update form for each service location address change.

Provider Name: _____ County: _____

DBA Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____Telephone: _____Ext: _____ Fax:_____

E-Mail Address: _____Effective Date: _____

2. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity who has ownership of the above service location. The legal name must be the current name registered with the Secretary of State. This name will appear on corporate, tax, and other legal documents. If more than one legal name is currently used by this business entity, attach an explanation listing each name. The address must be a physical location. A post office box is not a valid home office address.

Legal Name: _____

Street Address: _____

City: _____State: _____ Zip + 4 _____

Contact Person: _____Telephone: _____Ext._____ Fax:_____

E-Mail Address: _____ Effective Date: _____

3. Mailing Name and Address

Please complete the contact information for addressing bulletins, provider manual updates, and general correspondence, **if different from the Service Location Address.** A post office box is an acceptable mailing address.

Name _____

Street Address _____

City _____ State _____ Zip + 4 _____

Contact Person _____Telephone _____ Ext. _____ Fax: _____

E-mail Address _____ Effective Date _____

4. Pay To Name and Address

Please complete the contact information for addressing checks, remittance advices, and general claims payment information, **if different from the Service Location Address**.

Name _____

Street Address: _____

City _____ State _____ Zip + 4 _____

Contact Person _____Telephone _____Ext. _____ Fax _____

E-mail Address _____ Effective Date _____

5. Billing Agent Name and Address

Please complete the contact information for addressing checks, remittance advices, and general claims payment information, **if different from the Pay To Address, or if none, the Service Location Address.**.

Name _____

Street Address _____

City _____State _____ Zip + 4 _____

Contact Person _____Telephone _____Ext. _____Fax _____

E-mail Address _____ Effective Date _____

Important. Sections 6-10 require copies of the following documents for verification as applicable.

- ❑ Completed Current Federal W-9 Form
- ❑ Practitioner License from Licensing Board
- ❑ Clinical Laboratory Improvement Amendment (CLIA) Certificate
- ❑ Federal Drug Enforcement Administration (DEA) Certificate
- ❑ Medicare Provider Number Assignment Letter

6. Federal Tax Information Update? ___ Yes Effective Date _____

Please complete this field with your federal Taxpayer Identification Number (TIN) if you are undergoing or have recently undergone a TIN change. If you are undergoing or have recently undergone a change of ownership, then you must complete a Billing Provider Enrollment Application for each service location changing ownership.

Taxpayer Identification Number _____

Have you undergone a change of ownership**?** ___Yes ___ No

Is the new tax ID the tax ID of a Practice Management Company? ___ Yes ___ No

NOTE: If you answered yes to either question, you must complete a Billing Provider Enrollment Application for each service location affected by the change in ownership or practice management. You must hold all claims until you receive confirmation of your new provider number(s) and service location.

7. Provider Specialty & Licensure Information Update? ___ Yes

Please complete the information about your licensure and your specialty. Please refer to the ISDH Provider Specialty List to determine the specialty numbers for your primary specialties. Primary and secondary specialties must be from the same provider type.

Add an additional Specialty _____ Remove a Specialty _____

Change Primary Specialty _____ Change Secondary Specialty _____

License/Registration/Certification Number _____

Effective Date _____ Expiration Date _____

NOTE: A copy of the license from the appropriate licensing board / agency must be attached to this form. Failure to attach a copy of the license will result in ISDH returning the documents you submitted with a request for the missing information.

8. Clinical Laboratory Improvement Amendment (CLIA) Certification Update? ___Yes

Please complete this section with the information from your (CLIA) Certificate.

NOTE: A copy of the certificate must be attached with this form. Failure to attach a copy of the certificate will result in denied claims for laboratory services.

CLIA Number _____ Certification Type _____

Effective Date _____ Expiration Date _____

9. Federal DEA Certification Update? ___Yes

Please complete this section with the information from your Federal Drug Enforcement Administration (DEA) Certificate.

NOTE: A copy of the certificate must be attached with this form. Failure to attach a **copy of the certificate will result in denied claims for prescriptions you prescribe.**

DEA Number _____

Effective Date _____ Expiration Date _____

10. Medicare Participation Update ___Yes

Please complete the appropriate federal Identification Numbers.

Medicare Number _____Medicare Number State _____

Universal Provider Identification Number (UPIN) _____

DME Supplier Number _____

11. Voluntary Termination Update? ___Yes

If you are voluntarily terminating your participation in one of the ISDH Programs, please complete the date of voluntary termination and the termination reasons in the field below. Please note that all locations specified in the Provider Information Section will be terminated. If no locations are specified, then the entire provider number will be terminated. It is understood that any participants on the CSHCS Program that are now assigned to the Provider will be reassigned to another Provider and no other participants from the CSHCS Program will be assigned. To resume participation in the CSHCS Program the Provider needs to contact the Indiana State Department of Health, Provider Relations.

Programs: _____

Termination Date: _____

Termination Reason: _____

12. Provider-Authorized Signature

I certify, under penalty of law, that the information stated on this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the program and/or prosecution for Fraud. I hereby authorize the Indiana State Department of Health to make all necessary verifications concerning me, and my practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my participation in the Indiana State Department of Health Programs.

Signature _____ Date _____

Name _____

Title _____Telephone Number _____

13. Comments Section